**BEFORE THE APPEALS BOARD**
**FOR THE**
**KANSAS DIVISION OF WORKERS COMPENSATION**

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| **VOJIN DODIK** | ) | |
| Claimant | ) | |
| VS. | ) | |
| | ) | Docket No. 1,032,770 |
| **PENTAIR PUMP GROUP, INC.** | ) | |
| Respondent | ) | |
| AND | ) | |
| | ) | |
| **LIBERTY INSURANCE CORPORATION** | ) | |
| Insurance Carrier | ) | |

## ORDER

Respondent and its insurance carrier appealed the February 12, 2009, Award entered by Administrative Law Judge Marcia L. Yates Roberts. The Board placed this appeal on its summary docket for disposition without oral argument.

## APPEARANCES

Donald T. Taylor of Kansas City, Kansas, appeared for claimant. Mark E. Kolich of Lenexa, Kansas, appeared for respondent and its insurance carrier (respondent).

## RECORD AND STIPULATIONS

The record considered by the Board and the parties' stipulations are listed in the Award.

## ISSUES

Claimant injured his right shoulder on October 31, 2006, while working for respondent. In the February 12, 2009, Award, Judge Roberts held the evidence was

uncontradicted that claimant sustained a 20 percent impairment to his right shoulder due to his accident. The only doctor to testify was Dr. P. Brent Koprivica.

Respondent contends the Award should be modified as Dr. Koprivica's opinion regarding claimant's functional impairment is not supported by the criteria set forth in the fourth edition of the AMA *Guides*.[1] Respondent maintains the doctor measured claimant's impairment by considering three components; namely, loss of range of motion, loss of strength, and the structural change from undergoing surgery. Respondent, however, contends the *Guides* does not call for considering loss of strength in the absence of neurological injury or condition. In addition, respondent contends the *Guides* does not allow an impairment for the structural change in claimant's shoulder and the doctor also erred by using a table for distal clavicle resection in measuring the structural change. In short, respondent argues the appropriate use of the *Guides* yields an 11 percent functional impairment rating for claimant's October 2006 right shoulder injury.

Claimant requests the Board to affirm the Judge's finding that claimant sustained a 20 percent impairment to the right shoulder due to his October 2006 accident. Moreover, claimant contends respondent has failed to reimburse him for his medical mileage expense and, therefore, he requests the Board to award him "all valid and authorized medical expense, including mileage, up to and including today's date."[2]

The only issues before the Board on this appeal are:

1. What functional impairment did claimant sustain as a result of his October 31, 2006, accident?

2. Is claimant entitled payment of his past medical expenses including reimbursement for the mileage he drove associated with the medical care he received for his October 31, 2006, accident?

## FINDINGS OF FACT AND CONCLUSIONS OF LAW

After reviewing the entire record, the Board finds and concludes:

On October 31, 2006, claimant injured his right shoulder while working for respondent. Claimant, an experienced machine operator, injured his shoulder while

[1] American Medical Ass'n, *Guides to the Evaluation of Permanent Impairment* (4th ed.). All references are based upon the fourth edition of the *Guides* unless otherwise noted.

[2] Claimant's Supplemental Brief at 2 (filed May 11, 2009).

operating a 1940s-era machine when its handle broke. Claimant described the accident, as follows:

> It's an old machine, 1945, not work very well and I use extension pipe and handle. And pulling to me a rail post that go up and handle broke and pipe in hand, I hit myself in shoulder and fell down on my arm.[3]

The parties agree claimant's accident and the resulting right shoulder injury arose out of and in the course of employment with respondent.

As a result of his October 2006 accident, claimant underwent right shoulder surgery. Claimant, who is now 69 years old, was off work for 9 or 10 days until he returned to work on light duty and later resumed his regular job. Claimant now uses his left arm and shoulder to compensate for the permanent injury he has sustained to his right shoulder.

At the November 2008 regular hearing, claimant testified that he had lost strength and range of motion in his right shoulder. In addition, claimant noted he had ongoing difficulties with his right arm and shoulder and doing activities such as pulling, jerking, and working overhead. And that he could not move his right arm in a rapid fashion.

The record contains only one medical opinion, which was provided by claimant's medical expert, Dr. P. Brent Koprivica. The doctor is board-certified in both emergency medicine and occupational medicine, a diplomate of the American Academy of Disability Evaluating Physicians, and board-certified by the American Board of Independent Medical Evaluators. Dr. Koprivica estimates he has performed over 40,000 independent medical examinations.

Dr. Koprivica treated claimant in the 1980s for a right shoulder injury. In addition, the doctor examined and evaluated claimant in April 1996 for right shoulder injuries he had sustained in a 1994 work-related injury.[4]

According to Dr. Koprivica, the 1994 injury involved claimant slipping and falling while carrying a bucket of oil. As a result of that accident, claimant had some impingement in his right shoulder, some tearing of the labrum, injured his right biceps tendon, and partially tore one of his rotator cuff muscles. Claimant was offered surgery, which he declined. Nonetheless, claimant recovered from the 1994 injury and resumed his machine operator's job with respondent and did well until his October 31, 2006, injury. Claimant testified he was able to work without any problems after recovering from his 1994 accident.

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[3] R.H. Trans. at 9.

[4] Koprivica Depo., Ex. 2 and Ex. A.

Indeed, following his 1994 accident claimant resumed operating the 1940s-era machine that caused his October 2006 accident.

Dr. Koprivica explained that in the October 2006 accident claimant fully tore his right rotator cuff as the supraspinatus tendon was completely torn and retracted. That injury was different than claimant's 1994 injury in which he sustained a partial tear of the subscapularis. In the latter accident, claimant also tore his right biceps. An MRI taken in November 2006 also showed fluid both in the right shoulder joint and the subacromial bursa, which indicated an acute injury.

The doctor explained that claimant's right shoulder surgery, which was performed in June 2007, included removing some of the acromion and a ligament to make more space for the rotator cuff tendons, debriding the shoulder joint, and sewing the supraspinatus tendon back together. During the April 2008 examination, Dr. Koprivica found claimant lost range of motion in his shoulder due to the October 2006 injury on all planes; namely, abduction, adduction, flexion, extension, internal rotation, and external rotation. In addition, the examination revealed claimant had flexion weakness, which he did not have after his 1994 right shoulder injury.

For removing part of claimant's acromion, removing a ligament and debriding the glenohumeral joint, the doctor rated claimant's impairment at 5 percent for the upper extremity. The doctor testified the fourth edition of the *Guides* does not address those conditions and, therefore, he considered the 10 percent the fourth edition assigns for a distal clavicle excision. Moreover, the doctor assigned a 6 percent impairment for the right upper extremity due to claimant's weakness in shoulder flexion. The doctor acknowledged the fourth edition of the *Guides* neither has a table nor a methodology for determining impairment for shoulder weakness for other than neurologic deficit. Dr. Koprivica, however, used the table for neurologic deficit in evaluating claimant's impairment for shoulder weakness. Finally, Dr. Koprivica determined claimant sustained an 11 percent upper extremity impairment for the loss of range of motion that claimant sustained as a direct result of the October 2006 accident. When combined those ratings yield a 20 percent impairment to the right upper extremity at the shoulder level. The doctor explained his rating, as follows:

> And the things that I thought were new, first off, the structural changes associated with the surgery, the decompression that's been done, he didn't have that before, so that's new related to the 2006 [injury]. And I thought that was a consideration for contributing to the new impairment.
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> The second thing was the new weakness of flexion. He had already -- he already had weakness of abduction, so I wouldn't consider that as a component of the new impairment. But the flexion weakness is new.

And then the last thing was he had new losses of motion. And I had the comparison numbers from 1996 and normative data to look at to establish what those additional losses would reflect. For the weak -- for the decompression , the -- in the fourth edition of the guides, if you do a decompression where you take off the end of the collarbone, it assigns a 10 percent. I was somewhat conservative in what I would assign for his structural change.

But in his case, they removed part of the acromion, took out the ligament, debrided the glenohumeral joint. Those components are -- those are considerations for impairment. I assigned 5 percent using that 10 percent that the guides assigned for removing the distal clavicle, just for comparison purposes. You could justify ten, but it *[sic]* I thought that would probably overstate the ultimate impairment. And so I've kind of discounted for that.[5]

. . . .

For the weakness, [claimant] clearly has impairment on weakness. We -- the definition of impairment in the guides is if there's a loss of ability to do activities of daily living; and weakness of flexion of the shoulder limits your ability to do activities of daily living.

So by definition, he has an impairment. And the question is, well, is how much do you assign? In the fourth edition of the guides there is some deficiency on how you assign impairment for weakness, because they only assign it on neurologic deficits. They don't say that if you're weak from anything else, you don't have an impairment, they just don't give you a number or table to refer to. In the fifth edition they did specifically look at that and went ahead and assigned numbers because of that deficiency.

You can use the fourth edition of the guides, calculate out what the impairment would be if it was based -- if the weakness was based on neurologic deficit, and come up with a number. That number will be identical to the numbers that they have in the fifth edition of the guides, in their specific table where they assign impairment weaknesses based on Grade 1, 2, 3, 4, 5. They actually do a range of impairments, but they are using the same rating type system that the fourth edition of the guides uses for determining weakness.

With that in mind, for the new weakness in flexion, I assigned 6 percent. So 5 percent for the surgery, 6 percent for the new weakness of the shoulder due to this injury. For the motion deficits, the flexion loss that's all new is 3 percent. The extension loss, which is all new due to this 2006 [accident], is 1 percent. The new -- the abduction loss, which is all new compared to '96, is 3 percent. The adduction

[5] Koprivica Depo. at 24-25.

> loss, which is all new compared to 1996, is 1 percent. External rotation is all new, that loss is; that gets 1 percent.
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> And then the internal rotation, there was impairment before, there's greater impairment now. The overall impairment for how he presents today is 4 percent for loss of internal rotation. What he had before was 2 percent. So I just subtracted the 2 from the 4, and that leaves 2 percent that's new.
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> Under the method of the guides, you add the motion deficit impairments. Those add up to 11 percent. So we have 5 percent for surgery, 6 percent for new weakness, 11 percent for loss of motion due to the 2006 injury. You combine those using the Combined Values Chart on page 322 in the fourth edition of the guides; that's 20 percent. So I felt the new impairment isolated to the 2006 injury was 20 percent.[6]

As indicated above, Dr. Koprivica was the only medical expert to provide an opinion regarding the functional impairment claimant sustained as a result of his October 2006 right shoulder injury.

A shoulder injury is included in the schedule of K.S.A. 44-510d, which provides that loss of a scheduled member shall be based upon the permanent impairment of function as determined by the fourth edition of the AMA *Guides*, if the impairment is contained in that publication.[7]

Respondent does not challenge that claimant sustained impairment due to the additional loss of range of motion that claimant sustained due to his October 2006 injury. Dr. Koprivica's testimony is uncontradicted that claimant sustained impairment to his shoulder due to the residual muscle weakness caused by his rotator cuff tear. Consequently, the Board finds the muscle weakness caused by the rotator cuff tear created impairment, which, according to Dr. Koprivica, is recognized and rated in the fifth edition of the AMA *Guides*. The Board also finds the acromion decompression and removal of the ligament from claimant's shoulder also created impairment due to the structural change in claimant's body. When an impairment or condition is not addressed in the fourth edition of the AMA *Guides*, a medical expert can resort to other criteria and sources other than that publication to rate the impairment.

The Board finds Dr. Koprivica's functional impairment opinions credible. Accordingly, the Board finds and concludes that claimant has sustained a 20 percent

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[6] *Id.* at 25-27.

[7] K.S.A. 44-510d(a)(13) and (23).

impairment to his right upper extremity at the shoulder level for which he is entitled to receive permanent disability benefits as provided by K.S.A. 44-510d.

Employers are responsible for providing transportation for injured workers to obtain medical services. And, as provided by regulation, when workers drive their own vehicles, they are to be reimbursed that mileage expense.[8] Consequently, respondent is required to reimburse claimant his medical mileage expense as provided by regulation.[9]

As required by the Workers Compensation Act, all five members of the Board have considered the evidence and issues presented in this appeal.[10] Accordingly, the findings and conclusions set forth above reflect the majority's decision and the signatures below attest that this decision is that of the majority.

## AWARD

**WHEREFORE**, the Board affirms in part and modifies in part the February 12, 2009, Award entered by Administrative Law Judge Marcia L. Yates Roberts. In addition to the orders entered by Judge Roberts, the Board adds that respondent and its insurance carrier are required to pay all valid and authorized medical expense, including medical mileage, that claimant has incurred for treatment of his October 31, 2006, right shoulder injury; subject, of course, to regulation and the Director's fee schedule.

The Board adopts the remaining orders set forth in the Award that are not inconsistent with the above.

**IT IS SO ORDERED.**

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[8] K.A.R. 51-9-11(c).

[9] According to a letter received by the Board from Mr. Kolich dated June 24, 2009, respondent has allegedly paid claimant $1,373.81 for prescription and mileage expenses.

[10] K.S.A. 2008 Supp. 44-555c(k).

Dated this ____ day of June, 2009.

BOARD MEMBER

BOARD MEMBER

BOARD MEMBER

c: Donald T. Taylor, Attorney for Claimant
Mark E. Kolich, Attorney for Respondent and its Insurance Carrier
Marcia L. Yates Roberts, Administrative Law Judge